

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-028488

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

7013

STATE FILE NUMBER

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FILED JUL 31 1962

1. PLACE OF DEATH
a. COUNTYb. CITY (If outside corporate limits, give TOWNSHIP only)
OR
TOWN

St. Louis

Length of stay in 1b

c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR
INSTITUTION

Homer G. Phillips

Inside Limits
Yes ☐ No ☐2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE **Missouri** b. COUNTYc. CITY
OR
TOWN **St. Louis**Inside Limits
Yes ☐ No ☐d. STREET ADDRESS
(If outside, give location)
4128 FinneyReside on Farm
Yes ☐ No ☐3. NAME OF DECEASED
(Type or print)First Middle Last
Hattie Luevenia Brown4. DATE
OF
DEATHMonth Day Year
7 14 62

5. SEX

Fem.

6. COLOR OR RACE

Negro7. Married ☐ Never Married ☐
Widowed ☒ Divorced ☐

8. DATE OF BIRTH

11-29-1891

9. AGE (last birthday)

70

IF UNDER 1 YEAR IF UNDER 24 HR

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Clerk

10b. KIND OF BUSINESS OR INDUSTRY

Delicatessen

11. BIRTHPLACE (City and state or country)

unknown

12. CITIZEN OF WHAT COUNTRY

USA

13a. FATHER'S NAME

unknown

13b. MOTHER'S MAIDEN NAME

unknown

14. NAME OF HUSBAND OR WIFE

- -15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service)**no**

17. INFORMANT

Address

Harold Owsley - 756 Bayard

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Respiratory FailureINTERVAL BETWEEN
ONSET AND DEATH
UnknownConditions, if any,
which gave rise to
above cause (a),
stating the under-
lying cause last.

DUE TO (b)

Hypoxia

DUE TO (c)

Cardiac Insufficiency, Pleural Effusion

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

4.22.2

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☒ No ☐ Unknown19. WAS AUTOPSY
PERFORMED?
YES ☐ NO ☒20a. ACCIDENT SUICIDE HOMICIDE
☐ ☐ ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF
INJURY Hour
a.m. Month, Day, Year
p.m.20d. INJURY OCCURRED
WHILE AT WORK ☐
NOT WHILE AT WORK ☐20e. PLACE OF INJURY (e.g., in or about home,
farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from **7-5-62** to **7-14-62** and last saw her **xx** alive on **7-14-62**
Death occurred at **9:30 P.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Name or title)

22b. ADDRESS

2601 N. Whittier

22c. DATE SIGNED

7-16-6223a. BURIAL, CREMATION,
REMOVAL (Specify)**Removal**

23b. DATE

7-18-62

23c. NAME OF CEMETERY OR CREMATORY

Washington Park Cemetery

23d. LOCATION (City, town, or county)

Berkeley, Mo.

(State)

24. FUNERAL DIRECTOR

ADDRESS

ATKINS BROS.**3644 Finney Ave.**

25. DATE RECD. BY LOCAL REG.

JUL 17 1962

26. REGISTRAR'S SIGNATURE

Lois Smith, M.D.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

John K. Cunningham

Licensed Embalmer No. 4476

P. O. Address 2405 Marcus

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.